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ABSTRACT

Facts about mental and emotional illness and implications for student mental health services in higher education are reviewed. Psychoses, which are types of mental illness that are usually quite severe, are discussed in terms of symptoms, as are neuroses, which cause severe distress and impair coping with living conditions but are not as debilitating as psychoses. Examples of childhood experiences that may result in mental illness are briefly discussed. Based on a literature search of the Educational Resources Information Center database, 41 citations directly related to this topic were found. The citations are reviewed and categorized as follows: functions, facilities, and services of college mental health centers; staffing of college mental health centers; clients of college mental health centers; and evaluation of college mental health centers. The 41 documents suggest that while some institutions offer comprehensive mental health services, many do not. Some constructive things a student might do as self-help are identified: talk it out, escape for a while, work off anger, give in occasionally, do something for others, take one thing at a time, shun the "superman" urge, go easy with criticism, give the other person a break, make oneself available, and schedule recreation. It is suggested that if more in-depth help is needed, professional assistance of a counseling and guidance service may be helpful, or treatment by a clinical psychologist, psychiatrist, or mental health professional may be needed. A bibliography is appended. (SW)

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STUDENT MENTAL HEALTH SERVICES IN HIGHER EDUCATION

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by

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STUDENT MENTAL HEALTH SERVICES
IN HIGHER EDUCATION

OVERVIEW

How great is the need for mental health services in the United States? It has been estimated that one in every seven individuals, (about 32,000,000) have some form of mental or emotional illness. The severity of the problems ranges from quite mild to quite severe, and these ill individuals would benefit from competent professional help. The broad extent of this problem is evident in the following two statistics:

1- About twenty-one million families have someone in their household affected by mental illness.

2- More than one in each four families are thus afflicted.

Those who familiarize themselves with the facts about mental and emotional illness are better equipped to deal with the problems; i.e. individual; family; on campus, etc. And probably the most important fact to bear in mind about mental illness is that it is an illness; an illness which - with proper care and treatment - can result in those so afflicted getting better and returning to leading normal lives. A direct corollary of this fact is that asking, or telling, a mentally ill person to "snap out of it" is just about as helpful as expecting someone with a broken leg to "forget about it". It is of no help whatsoever and may even worsen the situation.

What are some of the salient facts about such mental and emotional orders which affact the lives - both directly and indirectly - of so very many people? Following are terms which identify several different disorders of the mind which affect the manner in which individuals behave; feel; think. In general, it is rare that such disorders/illnesses appear suddenly. Usually there are some early signs which qualified mental health professionals can identify long before a mental 'breakdown' occurs.

Psychoses:

This term identifies a type of mental illness which is usually quite severe. Quite often, it is characterized by the following symptoms:

1- The individual 'lives' in an imaginary world. However, they usually do recognize something of what goes on in the real world to which the non-psychotic respond.

2- The psychotic individual may 'hear' voices; think his food is being poisoned; believe everyone is out to "get him"; may be either extremely depressed or highly agitated; may feel something terrible is about to happen to him or that he has committed a heinous crime for which he is being punished; may imagine he has magical powers or that he is a famous person, (so-called delusions of grandeur).

3- During the course of his illness, the person suffering from a psychotic condition has very little control over his actions, feelings, and thoughts.

4- Despite folklore 'wisdom' to the contrary - most psychotic individuals are not insensitive. Many suffer mental anguish intensely, and most respond gratefully to kindness, attention, and assistance.

5- Again - despite common belief - only a few individuals become overactive or violent among those suffering from this serious mental illness. Most are quiet, unexcited, out of touch with reality during their illness.

6- So-called "organic psychoses" are those stemming from some physical causes. These might be nervous system injuries, such as brain damage; the effects of poisonous chemicalson the body - and mind; severe alcoholism; an advanced, exacerbated infection. Others could result from bodily changes; e.g., those brought about by senility; hardening of the arteries; drugs.

7- The so-called "functional psychoses" are those for which there are no known physical causes; i.e. bodily dysfunctions. Examples are paranoid and

affective psychoses. The most common functional psychosis is schizophrenia. It continues to remain one of the most baffling.

8- In recent years there has been a marked increase in the numbers of psychotic individuals successfully returning to normal behavioral, feeling, and thinking functions. In general - almost anyone suffering from a psychosis does benefit from competant professional treatment; the earlier treatment is begun, the better the prognosis for recovery. Improved care in mental hospitals; new, modern treatment services, (mental health services in general hospitals; community mental health centers); and the therapeutic drugs effectively used to control many symptoms of severe mental illness, have all contributed to this overall improvement in the treatment, care, and recovery of these mentally ill individuals.

Neuroses:

The terms used for the types of mental illness which may cause a person severe distress and impair their efficiency to cope with living conditions in a 'normal' manner ; e.g. neuroses or psychoneuroses. These conditions can be as debilitating as psychoses, although quite frequently the symptoms are not as severe. Some characteristics of these disorders are:

1-The condition may be so serious as to prevent a person from carrying on with his job; his schooling; his family. It might, when severe, require treatment in a hospital or other mental health facility.

2- A neurosis may be moderate in intensity, permitting the individual to keep up his normal, daily routine but requiring some type of therapy - not necessarily in a hospital.

3- Symptoms associated with neuroses might include one or more, or a combination, of the following:

(a) feeling unloved, inferior, inadequate - often without reason.

(b) excessive shyness

(c) a constant sense of guilt

(d) dread and fear

(e) chronic tardiness and nervous tension

(f) sleeplessness or the constant fear of physical illness to the point of imagining that one has "all the symptoms"

(g) certain pronounced phobias, such as fear of high or closed-in places

Virtually everyone has some of these feelings some of the time, but the neurotic person has them to a greater, (i.e., more intense) degree most of the time.

4- Neuroses may also reveal themselves in various physical symptoms. Many disorders - stomach ulcers; diabetes; arthritis; high blood pressure may be emotional in origin. An everyday example of the effect intense emotions can have on the body is the so-called "nervous headache".

DEALING WITH MENTAL PROBLEMS

Like physical upsets, emotional upsets are very common. Both are signs that the individual's system is reacting to some temporary stress, irritation, disturbance which disrupts its routine, (i.e. 'normal) functioning. Simple, minor emotional disturbances are a part of everyday life; everyone is subject to them. For example, it is quite ordinary for someone to fly into a rage over some petty annoyance; we simply say they have a short temper. Or - it is hardly unusual for someone to get terribly worried about some insignificant trifle; we might call them a "worry wart" or some similar comment. And who hasn't, at some time or other, been "down in the dumps" for no apparent reason. Such everyday reactions come; they last awhile; they then disappear - nothing unusual or spectacular about it - perfectly 'normal' behavior.

However - there are some disturbances which simply don't go away "just like that". They linger on for hours; sometimes days; even weeks. They become quite deep, and intense: they affect the individual's overall behavior, feelings, thoughts. When a mental-emotional state reaches this point, it no longer is simply an upset, disturbance, passing mood: it has developed into a mental/emotional illness. At this point one is dealing with a disturbed personality - those troubled people experiencing disruptive - at times disabling - mental or emotional problems.

Being an illness - such mental and/or emotional problems should be regarded with the same attitude as one does physical illness. It is now well-established that such mental-emotional illnesses have:

1- definite causes
2- upset the system and make it behave abnormally
3- require care and treatment: when these are made available, improvement or outright recovery may be anticipated.

Such individuals suffering from emotional-mental illnesses are of clear concern to their community at large because what they say and do generally affects everyone else who works, studies, or lives with them. Additionally, they are also of concern as sick human beings: they are people <u>in need of understanding</u>.

Today, it is generally accepted among mental health professionals that <u>understanding</u> can keep minor upsets from becoming worse conditions, and that such empathic understanding can also help mentally ill individuals to recover; more rapidly, more completely.

Understanding can take two forms; the first is sympathetic understanding. This is the kind commonly extended to persons when ill with a physical ailment. Such sick people may cause extra "trouble", but in spite of this, one makes allowances and recognizes that the sick person <u>can't help being ill</u>! One does not question that such sick people need both sympathy and understanding.

The mentally-emotionally troubled person is equally 'sick'. Even though

what he may do is disturbing to others, he too is just as much in need of sympathetic understanding as the physically ill person.

The second type of understanding is rational understanding. This relates to an understanding of what's behind mental problems and why troubled people behave the way they do. This type of understanding helps one to keep things in perspective. It helps to put one in a reasonable frame of mind to deal with the troubled person; in short - to help him rather than fight him.

Troublesome people are people in trouble! The first step in understanding them is to realize that his disturbing behavior, or problem behavior, may well be more painful to him than to anyone else. One should further recognize that troublesome behavior without apparent cause may be the effect of an emotional illness rather than a fault of character.

Some examples of disturbing behavior which indicate that a person is in emotional difficulty includes: belligerance; excessive moodiness; exaggerated worry; suspiciousness and mistrust; selfishness and greediness; helplessness and dependency; poor emotional control; day-dreaming and fantasy; and hypochondria.

Usually, individuals experiencing mental problems have reached the level of illness as a result of earlier experiences. These distort their normal emotional responses and set up in them inappropriate and ineffectual ways of dealing with life situations. Each person is born with the capacity to be gentle, friendly, loving, considerate, and kind. Additionally - people have the capacity to be fearful, suspicious, hateful, angry, destructive, and cruel. These latter, negative emotions may serve the purpose of self-preservation; i.e. they may act as devices to protect the individual from physical danger, (like an attack by a dog), as well as from psychological danger, (such as an insult, scolding, or insecurity on the job). Confronted by either kind of threat, one is prone to get

3- Amaranto & Wegman (1977) report on the active growth of a mental health service in an academic health center; urban area: (New Jersey Medical School). In their view, the significant characteristic of its functions is its limitation; i.e. confined strictly to therapeutic and consultative services for the students. It operates as an outpatient treatment facility, using a standard 12-session, goal-oriented treatment plan.

4- Shaevitz (1977) describes the dilemma faced by campus mental health counseling professionals in seeking to maintain 'quality' services while operating under tight budget limitations.

5- Babineau & Schwartz (1977) report encouraging results for solo therapists with adequate background in individual and couple therapy; (who also have additional training-experience in sex therapy) in providing treatment for sexual dysfunction to student couples in a health service setting.

6- Keepes (1976)in his article is concerned with the various preventive measures which can be taken to minimize student emotional difficulties arising from collegiate campus living. Facilities on other campuses are reviewed, and specific recommendations offered for a facility designed to fit its campus.

7- Lewis & Neidig (1977)discuss a successful, cooperative, short-term, crisis intervention mental health program developed between Fulton-McDonough councty community health center and the health service of Western Illinois University, with a fulltime consultant provided by the county health center and compensated by the university.

8- Nigl & Weiss (1977: "Effects of ...etc") conclude from the results of a statistical study of student responses to a questionnaire designed to assess subjects' feelings regarding treatment in a university mental health center program, that college-university students can be treated effectively with brief psychotherapy.

STUDENT MENTAL HEALTH
SERVICES IN ACADEME

For students troubled by emotional or mental problems, there are a number of things one can do, as well as some things that should be avoided. (These are discussed in Appendix A for those seeking this type of information)

The need for student mental health services is the self-same need previously noted. Approximately 1 out of each 7 Americans have some form of mental or emotional illness, and of these 7 million individuals, it is estimated that less than one third of these troubled people needing mental health assistance are receiving it.

A computerized literature search of the ERIC system; i.e. Educational Resources Information Center sponsored by the National Institute of Education, yielded some 92 citations. Of these, 41 were directly related to this topic. These are discussed in the following numbered paragraphs. To facilitate review of this substantive number of documents they are organized under the following principal topics:

A - Functions, facilities & services of college mental health centers
B - Staffing of college mental health centers
C - Clients of college mental health centers
D - Evaluation of college mental health centers

A - Functions, facilities & services of college mental health centers:

1- Hazard (1976) reports on a workshop discussing new trends in campus health care delivery. Emphasis was given to the repercussions of strong consumer demands for broader and more accessible health services and concerns to improve campus/community relations. The need for mental health care as an on-going dimension of a comprehensive health care service was stressed.

2- Amada (1976) examines, through the results of a survey, the presence of mental health services and programs among two-year, public, community colleges. His conclusion: a serious paucity exists which needs to be recified.

frightened and run, or one might turn on the source of danger and try to destroy it or overcome it.

Should something happen in our lives to make us continually defensive or hostile, then this kind of response becomes more or less fixed as part of our regular way of behaving; even when no real threat is present! Such defensive or h ostile behavior may develop as a result of several different kinds of experiences - especially in childhood. Among these are:

1- A long and wearing seige of illness; trouble; tragedy; or hard luck. This kind of situation can condition a person to be on a constant alert for trouble.

2- A state of constant doom-and-gloom in the home. If from infancy on, a child is surrounded by an air of fretting and complaints, he may grow up with the impression that the world is full of nothing but trouble, and that everyone is trying to take advantage of him. In effect, he is conditioned to anticipate trouble even when none exists. This attitude, formed in early childhood, tends to persist in adult life.

3- Neglect or rejection in childhood. A child who is ignored or disliked may tend to feel this is his own fault; that he lacks the qualities to make him lovable and acceptable. The self-deprecating child becomes an adult full of insecurity, self-doubt and fear; lacking confidence and self-assurance and expecting to be hurt, ignored, rebuffed.

4- Constant scolding and criticism. This may give the child an exaggerated feeling of guilt and a feeling he is inferior, worthless, essentially bad. He is conditioned to expect that everyone will find fault with him and punish him.

Quite obviously - such experiences differentially affect children, for some can stand emotional stress better than others and suffer fewer lasting, serious effects.

9- Schwart (1977) describes a novel group experience in career choice decision-making which permits students to receive help without identifying themselves as patients or clients. The therapeutic benefits are related to the satisfaction of psychological needs.

10- Rockwell (1977) suggests that brief group treatment is not a generally applicable device for managing students or for conserving staff time in health centers. His recommendation: fulltime utilization of individual counseling to help insure positive prognosis.

11- Miller (1976) offers two case descriptions which illustrate the work performed by a community college counseling service. The applicability of the term "psychotherapy" to the therapeutic services rendered is discussed in depth. The applic ations for community mental health of such medical and educational services are examined briefly.

12- Demos (1976) describes the highlights of a symposium which examined the general roles and functions of a college counseling center and of the professional personnel in it, focusing upon the fostering of positive mental health among college-age youth.

13- (1971) discusses, indepth, a mental health program at an urban community college; with emphasis placed upon the proving of crisis intervention services.

14- Nidor (1970) delineates the establishment and operation of a student services center at San Fernando Valley State College designed to assist students, through a program of active intervention, to effect more satisfactory psychological adjustments to their collegiate environment.

15- Hunter (1969) discusses the role which can be played by a college mental health center clinic in identifying potential problem drinkers among college students.

16- Sinett (1969) focuses upon the effective utilization of the rehabilitation unit - a new response for the emotionally disturbed student.

17- Western Interstate Commission for Higher Education (WICHE) (1974) released a report discussing consultation as a process of assessment; defining; implementing; evaluating. These steps, as noted, are functionally interrelated in a described plan of a consultation function for a student mental health service.

18- WICHE (1974) This detailed report discusses how life on campus has been affected by changes in society, and changes in the university's role. It illustrates how the change in priorities can be instrumental in resolving campus problems, and details the implications this holds for changing mental health delivery systems on campuses.

19- WICHE (1972) A comprehensive report which suggests that through the promotion of student unity, they can gain the necessary power to engage in representation conflict which will change the monolithic nature of education and present open, destructive conflict with the system. New designs promoting student responsibility, authority, and participation are discussed. These imply that mental health delivery systems on campus will have to become more open and involved, with community programming and participation.

20- National Institute of Mental Health (1973) A broad spectrum of facts about college mental health are presented. Areas of concern include common conditions interfering with student effectiveness; why students seek help, and where they can get it; the frequency of severe mental illness among college students; the suicide problem; the limitations of non-professional help; the concept of dependency and counseling; methods of counseling used in a college setting; the relationship of violence to mental illness; availability of mental health services; the role of the college psychiatrist; the ratio of mental health services on college campuses.

21- Micoletti (1973) reports the results for forty undergraduates referred by counseling centers for anxiety management training (AMT). The AMT was found to be effective in reducing both generalized and public-speaking anxiety.

22- American College Health Association (1972). The basic premise of this

document is that every two-year college should have a plan through which the health needs of students, faculty, and staff members can be met by available health services that are accessible and of high quality. Procedures for setting up a comprehensive health program are reviewed; various services and activities to be included are discussed in depth, Also described are the health personnel and physical plant and facilities necessary for a complete program. In addition, the business management procedures of a sound health program service are described.

23- Texas Tech University (1970). This paper contends that university campuses must find a reasonable, responsible, and financially-sound basis for student mental health services. Results of responses by 73 universities to a psychiatric questionnaire survey are summarized; conclusions are drawn; recommendations are offered.

24-Kysar (1966) College level preventive psychiatry should be directed toward biological, intrapsychic, familial, and social, interpersonal strains which disturb and distort students' learning experiences, often causing short-term emotional difficulties. It is the author's firm belief that colleges have a unique opportunity to provide mental illness prevention programs.

25- Kysar (1964) The combination of students from broken homes; from homes of lower socioeconomic status; and students who have individual pathologies, result in a high rate of and a more severe psychopathology in day-commuter schools than in residential schools studentbodies. The author concludes that the strong relationship exisiting between psychosocial difficulties and college dropouts indicates the need for better college mental health programs.

B - Staffing of College Mental Health Centers:

26- Sue (1974) Discusses a program to provide more responsive counseling services, in which minority students are trained to function as counselors for other minority students. He concludes that the training and utilization of

minority group para-professionals, as appropriate, are favorable alternatives to existing mental health services on college campuses.

27- Winer (1975) suggests, after a survey among clinic and mental health center directors, that many mental health professionals are not fully meeting their responsibilities to nonwhite students in the area of mental health services.

28- Chirchirillo (1977) addresses the general problem of mental health resources on most college campuses. They are being taxed to their limits. He further discusses the feasibility of offering a program to develop the faculty's "counseling skills". He concludes that such training is a feasible community mental health approach to the college campus.

29-Jones & Najora (1977) conclude that in mental health illness intervention; (i.e., crisis-therapy) , for undergraduate students, effective interaction among mental health staff members and naturally-concerned individuals; (e.g., parents; friends; teachers), can be viewed as a network of help in such acute crisis intervention circumstances.

30- Szasz (1976) The principles of conduct governing college psychiatrists and the relationship between these authorities and their subjects are examined. The author concludes that much of the college psychiatrist's work consists of crisis intervention, and he is a powerful status figure with vast powers over students.

C - Clients of College Mental Health Centers:

31- Nigel & Weiss (1977) Forty-five students at the University of Cincinnati responded to an opinion survey questionnaire concerning student attitudes toward the treatment they received in the health center, as well as relevant consumer; demographic; environmental variables.

32- Sue & Sue (1975) found cultural differences between Asian students as compared with control groups in the use of clinic services. The Asian

students under-utilized the clinic and also possessed more pronounced Minnesota Multiphasic Personality Inventory scale elevations. Additionally, they exhibited problems involving somatic complaints; family discord; social introversion.

33- Reinhold (1973) analyzes the clientele utilizing mental health services and the extent of such services at the University of Pennsylvania.

34- Ladvinka & Denner (1972) discuss a project of college student involvment in community-oriented health services relating to mental illness.

35- Reifler (1971) summarizes information available on the prevalence of emotional disorders in the college experience. Data on the characteristics of users point toward the increasingly recognized importance of social affiliation; not only on mental health states but upon disposition to seek professional services.

36- Heilbrun (1970) assesses ability of the Adjective Check List to distinguish between clients of a college mental health facility who admitted to social alienation as a primary or secondary problem, in contrast to clients who denied the importance of this problem. Scores on the various scales differed significantly for the 'problem' and 'no problem' client groups, as well as male and female.

37- Thelan & Varble (1970) report comparisons of college students seeking psychotherapy with a similar group not seeking therapy. The former generally had higher defense and lower coping scores than the latter. They conclude that colleges have an opportunity to offer students a unique student personnel service - a mental health prevention program.

38- Wogan (1975) discusses the effects of pre-training counseling clients for group therapy sessions. The findings suggest that types of pre-treatment employed were relatively ineffective in influencing the subsequent process in the groups. The interaction seemed to be much more highly influenced by level

of activity of the leader. Groups which rates themselves as most improved tended to be those in which there was more discussion of personal feelings and where the leader was more active.

39- WICHE (1973) provides in this document a research design by which to gather accurate, descriptive, base-line data on campus and student characteristics so that mental health personnel can assume a proactive role in the planning and conduct of educational programs that ameliorate student problems and/or enhance school and student educational goals.

D - Evaluation of College Mental Health Centers:

40- Michaels & Reifler (1977) suggest that mental health programs, in addition to providing health services that are justifiable in cost/benefit analysis, provide services promoting the quality of life. The latter, they note, are not justifiable from this cost/benefit viewpoint and must compete with other humanistic university programs.

41- Whitaker (1977) presents data relating to research and statistical surveys on student health services and problems at community colleges which reveal administrative attitudes; student health care needs; needed areas for improvement. Providing health care for students is said to be generally overlooked by community college professionals who feel it should not be the college's responsibility. A lack of both medical treatment facilities and mental health programs on community college campuses is identified. Suggestions for implementing comprehensive health care programs are offered.

A FINAL COMMENT

The 41 documents abstracted immediately above suggest that the "state of the art" for mental health services offered to students attending colleges and universities throughout the country is rather 'uneven' , to say the least! Although there is evidence that some institutions offer comprehensive mental

health services, it is also quite evident that for numerous others mental health services are conspicuous by their absence!

Among college students, as well as others, the quest for peace of mind, (or good mental health!), is a universal one. The average human being has the capacity to live through emotionally upsetting situations - even crises - and bounce back when they are over. It is therefore important for a student to recognize than an occasional bout of anxiety and tension is quite normal. While it may be unpleasant - even painful - it need not be a cause for grace concern.

However - there are some students, (and others, too) , for whom life is but a series of little and big crises. In such instances one might expect more than an occasional, passing upheaval of emotions. Signs of prolonged and intense anxiety may be anticipated. Thus - the time to become watchful is when emotional upsets come frequently; shake the student severely; persist.

How does one recognize that this build-up is taking place? Stated in the form of questions - following are some of the effects that show: if any considerable number of these reactions are becoming representative of the student's reactions it indicates the need to deal constructively and promply with the situation:

1- Do minor problems and disappointments throw the student into a dither?

2- Does the student find it difficult to get along with people, and are people having difficulty getting along with the student?

3- Do the small pleasures of life fail to satisfy the student?

4- Is the student unable to stop thinking of his anxieties?

5- Does the student fear people or situations that never troubled him previously?

6- Is the student suspicious of people; mistrusting his friends?

7- Does the student have the feeling of being trapped?

8- Does the student feel inadequate; suffer the tortures of self-doubt?

If the answer to most of these questions is "Yes", there are several things the student might do. First, there are certain simple, constructive things the student might do for himself. For the most part, these measures are positive forms of action: they are uncomplicated, ready-at-hand measures.

However - success will not come, even in these, if the student's effort is a halfhearted one. Nor will it come overnight: it will require determination; persistence; time.

(The following eleven numbered paragraphs are written as if addressed directly to the troubled students).

1. Talk it out:

When something worries you - talk it out! Whatever you do, don't bottle it up! Do confide your worry to some level-headed person you trust; your roommate, perhaps; a friend; parents; sister or brother; your clergyman; family doctor; a teacher, counselor; the dean. Fist of all - talking things out helps to relive your strain. It also will help you see your worry in a clearer light, and often it will help you see what you can do to ease the situation.

2. Escape for a while:

When things go wrong - sometimes it helps to get it off your mind - escape for a while from the painful problem. Lose yourself in a movie; an interesting book; a game; or perhaps a brief trip for a change of scene. Making yourseld "stand theere and suffer" is a form of unnecessary self-punishment: in no way will it help to solve the problem. Know that it is perfectly realistic and healthy to escape 'punishment' long enough to recover breathe and balance, (sometimes called "sense of perspective" or "sense of humor"!). But - be prepared to come back later to deal with your difficulty when you are more composed, and when you and others involved are in a better frame of mind to deal with it - sensibly; realistically.

3. Work off your anger:

If you feel yourself going around being angry most of the time remember that while anger may - temporarily - give you a false sense of righteousness, or even of power - generally it will end up with you feeling damfoolish and sorry in the end! If you feel like lashing out at someone who has proked you - try holding off the impulse for a while. Put it on the back burner; let it wait until tomorrow. Meanwhile - do something constructive with that pent-up energy. Pitch into some phsyical activity. Do you play tennis; or jogging perhaps? You might take a long walk- that can do wonders to take your mind off your troubles. Working off the anger in your system and cooling off for a day or so will leave you much better prepared to handle the problem; you can count on it!

4. Give in occasionally:

If you catch yourself getting into frequent quarrels withpeople; feeling obstinate; feeling defiant - try to remember; that's precisely the way frustrated children behave. If you know, or firmly believe something is right, stand on your ground. But do so in a non-belligent, calm manner; always remember, you want to make allowance for the fact that you could turn out to be wrong.

Look at it this way too; even if you're dead right - it's a lot easier on your system to give in once in a while. When you do yield, you'll usually find that others will join, too. If you can, no -will, do this occasionally the results, for you , will be relief from tension; achievement of a practical solution to being 'up tight' with people; a great feeling of satisfaction and maturity.

5. Do something for others:

If you find yourself worrying about you all the time, go do something for somebody else. You'll find this will 'defuse' your own worries and, even better, will give you a fine feeling for having done something considerate of others!

6- Take one thing at a time:

For people under tension and stress, an ordinary work load can sometimes seem unbearable. It looks so great that it becomes painful to try to tackle any part of it; even the things that most need doing. When that happens, remind yourself - it's a temporary condition and you can work your way out of it. The very best way to do this is to take a few of the most urgent tasks and pitch right into them - one at a time. Simply set aside all the rest for the time being. Once you have disposed of the urgent items you will see that those remaining are not such a 'horrible mess' after all! Before too long, you'll be in the swing of things and the rest of the tasks will go lots quicker, and easier. If you have the feeling that you can't set aside anything to get the job done by following this suggestion, just reflect for aa moment: are you sure that you aren't overestimating the importance of the things that you do - that is, you own importance?

7- Shun the "Superman" urge:

Some people expect too much of themselves, and get into a constant state of worry and anxiety because they think they are not achieving as much as they should. Their problem- they try to be perfect in everything. A wise person once said: "The pursuit of excellence is gratifying and healthy; the pursuit of perfection is frustrating, neurotic, and a terrible waste of time." You, too may be wise: decide which things you do well; then put your major effort into these. More than likely, they are things you like to do. As a consequence, they will give you the most satisfaction. When you have accomplished these then turn to the things you don't do as well. Give them the best of your efforts and ability; you can do no more than that! But whatever you do - don't take yourself to task because you can't achieve the impossible; you'll only be a loser all around - don't berate your self unreasonably !

8- Go easy with your criticism:

Some people expect too much of others,

and then feel frustrated, let down, disappointed, even "trapped" when another person does not measure up to our "too much" standard. The other person might be anyone; a brother, sister, friend, or relative whom we are trying, (not consciously, often) to fit into a preconceived pattern; perhaps even trying to 'make over' to suit ourselves. Well just remember - each person, including you, has his own virtues; shortcomings; values; and most importantly - his own right to develop as an individual. In a very real sense, people who feel let down by the shortcoming - either real or imagined - of their relatives, are really let down about themselves. Instead of being critical about the other person's behavior, search out their good points and help them develop these. Doing this will give both of you satisfaction and will also help you gain a better perspective on yourself - something worthwhile accomplishing!

5. Give the other fellow a break:

When people are under emotional tension, they often feel that they have to "get there first"; edge out ther person - even if the goal is as trivial (and dangerous!) as getting ahead on the highway! If enough of us feel that way, and many of us do, then everything becomes a race in which somebody is bound to get injured - physically, emotionally, mentally - in an effort to live a full life.

It really need not be this way. Although competition is contagious, so is cooperation. When you give the other fellow a break, you very often will make things easier for yourself: if he no longer feels threatened by you he stops being a treat to you.

Make yourself 'available':

Many of us, unfortunately, have the feeling at times that we are being "left out": we feel slighted; neglected; rejected. Quite often we are just imagining that other people feel this way about us when in reality they are eager for us to make the first move; they are shy,

hesitant, unsure of themselves. We may be making an error of judgement in deprecating ourselves! The healthy thing to do, instead of shrinking away and withdrawing, is to continue to 'make yourself available': you make some of the overtures, you make some of the effort to be friendly instead of always waiting to be asked.

Naturally, the opposite of withdrawal is equally non-productive; i.e. to 'push' yourself on every occasion. Quite often this type of behavior is misinterpreted and may lead to rejection. There is a 'balanced' middle-ground: don't 'push', don't withdraw - just relax and let interpersonal contact come naturally.

11- Schedule your recreation:

Many individuals drive themselves so hard that they allow themselves entirely too little time for R & R, rest and relaxation - an absolute essential for good health; physical and mental. They find it hard to make themselves back away from a driving time-schedule and simply take time out. To help break this 'habit' replace it with another time-schedule and routine - set up a program of definite hours when you will engage in some form of recreation - then follow this new routine; without fail! For virtually everyone, it is a 'smart' idea to have a hobby or interest that absorbs you in your 'off-duty' hours - one into which you can throw yourself completely, with pleasure and enthusiasm - forgetting all about studies, seminars, lab reports, term papers!

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There are times when any one of us might need in-depth help greater than that offered by the eleven simple suggestions summarized above. Under such circumstances it may be helpful to seek the professional assistance of a counseling and guidance service. They can, and do, help people clear up practical problems, and in doing so help relieve emotional strain and tension for the individual. However, if such emotional disturbances become too distressing to the student, or to others - this should be recognized and dealt with as a mental illness

condition requiring further professional treatment by a psychiatrist, clinial psychologist, or other mental health professional. If the student requires such help, get a specialist!

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Appendix A

Help Prevent Mental Illness

Although knowledge about the causes of mental-emotional illnesses is limited, there is a body of knowledge which, if used, can help prevent mental-emotional dysfunctions.

We DO KNOW there is:

1- a clear relationship between mental disorders and the lack of medical assistance. Therefore - we can presently prevent some forms of mental disorders by protecting the brain and nervous system through adequate prenatal, obstetrical, and early infant care. For senior citizens, we can make sure that comprehensive health care includes nutritional and other services relating to the distressing condition known as senility. We can support immunization programs for children, as well as early and periodical screening for physical and developmental mental disorders.

2- an obvious relationship between mental health and the way in which people learn to cope with some 'life crisis' situations. Certain life experiences are almost universal and they are of such a critical nature that programs can be designed to increase the coping skills needed to deal with them. It may not be possible to demonstrate that persons undergoing life crises would have developed mental illness had some intervention occurred. However, it is reasonable to assume that reduction of stress associated with the experience lowers the likelihood of emotional problems and future unhealthy coping practices.

Such crises include: admission to a hospital of a small child; separation of parent and child when the child just enters school; death in the family; the struggle for emancipation in adolescence; marriage; pregnancy; divorce; child-rearing; loss of job; prolonged unemployment; and retirement. Concentrated attention on preparation for effective handling of any specific critical

situation can have demonstrable effects. In addition - the training of teachers, employers, nurses, and even receptionists in health and service agencies to be aware of and sensitive to emotional stress can enable these people to avoid compounding stress. Such training can serve them also when it teaches them to make helpful interventions which provide emotional support to people under stress and needing reinforcement of their coping capabilities.

3- a distinct relationship between mental illness and excessive stress produced by the social system of which people are a part. While each of us has a degree of tolerance to stress, the pressure of multiple sources of significant emotional strain creates incresed likelihood of emotional breakdown. To prevent such breakdown, it is important to examine the social systems in which people live, and from which stress may be produced beyond the limits of coping capacity. Education; welfare; social services; medical systems, to name but a few, often diminish the benefits which they have to offer by bureaucratic rigidities and other forms of insensitivity which compound the stress of people already in need of help. Available evidence also demonstrates that the combination of hunger; crowding; discrimination; hopelessness in our city ghettos produces adaptive behavior which is mentally and emotionally unhealthy. Therefore - we can prevent mental illness by working to change these elements in our social systems which create multiple stress.

4- an obivous relationship between "labeling" and the prevalence of mental illness. It is clear today that much of what is thought of as mental illness simply does not belong within that classification. Thus we can, in a sense, "prevent" mental illness simply by a more enlightened understanding of individual behavior, and by avoiding the use of illness labels for behavior which is merely "different". For example - if we could develop a greater acceptance of extremes in behavior we would broaden the limits of "normality" and thereby reduce the

size of the population thought of as mentally ill. We should recognize that forgetfullness or vagueness of many elderly people stems from physical change due to the condition of aging, and it is not really mental illness.

This approach could reduce the stigmatized population substantively. It would not merely be a "nice thing to do" for it would help remove artificially created obstacles to a happy life, and would help to prevent the terrible tragedy of unnecessary long-term hospitalization.

5- an open-ended area of additional actions; i.e. as new techniques are developed; as new medications become available. It is generally accepted that the approaches decribed in 1 through 4 above can help prevent mental illness before it really gets started. Additionally -there are other things that can be done to prevent mild problems from becoming serious illnesses, or - to prevent mental illness from returning to those who have already experienced it. In the main- early identification of inappropriate emotional and behavioral responses to stress, coupled with proper diagnosis, and followed by prompt and adequate treatment, can result in the return to normal functioning without serious consequences to the individual. Further - specialized rehabilitation facilities operated by well-trained personnel can enable individuals who have been ill to become re-established in their social, educational, or employment lives. These 'returns-to-normal' help reduce long-range consequences of the illness as well as sharply diminish the likelihood of recurrence.

And finally - there are four types of action which should be scrupulously avoided. These are:

1- Don't set yourself up as a judge.
2- Don't tell the individual to "snap out of it".
3- Don't argue him down.
4- Don't try to be an amateur therapist!

If emotional-mental disturbances become too distressing to the troubled individual, or those around him, the situation

should be dealt with as a mental illness requiring professional diagnosis and treatment. Help should be sought: consult a mental health professional; someone who specializes in the treatment of mental and emotional conditions of distress. Such treatment is available through community mental health clinics; mental hospitals; mental health units of general hospitals.

Underlying everything that has been said in this article is a basic philosophy - have faith! It begins with having faith in ourselves; faith in others; faith in the ability of individuals to improve and grow; faith in the desire and capacity of human beings to work out their problems cooperatively; faith in the essential decency of mankind- at least, the better representatives of it! Following this basic philosophy is the best 'guarantee' to achieve, and maintain, sound mental-emotional health - adopt it!!

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References

Amada, Gerald. The Paucity of Mental Health Services & Programs in Community Colleges: Implications of a Survey. Amer. Coll. Health Assoc. Jrnl. 23. 5. 345-9/ June 1975.

Amaranto, Ernest: Wepman Barry J. Factors Affecting the Growth & Usage of a Student Mental H ealth Service. Jrnl of Med. Ed. 53.10. 849-51. Oct. 1976.

Amer. Coll. Health Assoc. The Development of Health Programs for Junior & Community Colleges: An Interpretation of Recommended Standards & Practices for a College Health Program. ERIC Resources in Education: Nat'l Inst. of Ed. May 1972. (ED 058871)

Babineau, Raymond; Schwartz, Allan J. The Treatment of Sexual Dysfunction in a University Health Service Setting. Jrnl of Amer. Coll. Health Assoc. 25.3. 176-81. Feb. 1977.

Chirchirillo, Andrew, and others. Training Faculty in Helping Skills: ACommunity Mental Health Approach to the College Campus. Jrnl of Nat'l Assoc. of Student Personnel Administrators. 14.3. 26-31. Winter 1977.

Demos, George D. & others. The Role of the College Counseling Center in Fostering Positive Mental Health Among College-Age Y outh. ERIC/RIE Jan 76. (ED 110871)

Hazard, Sprague W. Planning Campus Health Care Services. Planning for Higher Ed. 4.2. 415. April 1975.

Hellbrun, Alfred B. Adjective Check List Correlates of Social Conflict Problems in College Students. Measuring & Evaluating Guidance . 3.3. 158-163. Fall.'70

Hunter, George T. Identifying the Potential Problem Drinker in a College Mental Health Clinic. Jrnl of Amer. Coll. Health Assoc. 17.5. 426-36. Jan. '69

Jones, Ferdinand; Najera Gabriel A. The Helping Network: Reactions & Actions Stimulated by Students' Acute Mental Illness in aUniversity Community. Jrnl of Amer. Coll. Health Assoc. 2 4.4. 198-202. A ril '76

Keepes, Barbara. The University of Evansville Takes Advantage of Preventive Action for Mental Health. College Student Jrnl. 11.1. 16-41. Spring '77

Kysar, John. E. Preventive Psychiatry on the College Campus. Community Mental Health Jrnl. 2.1. Spring 1966. 27-34.

..... The Need for Mental H ealth Programming in the Commuter University. ERIC/RIE. Nat'l Inst. of Ed. 1967. (ED 011666).

Ludvinka, James & Denner, Bruce. The Limits of Success. Mental Hygiene. 56.2. 30-35. Spring 1972.

Leavitt, Alan, & others. Developing a Mental Health Program at an Urban Community College. Jrnl of Amer. Coll. Health Assoc.19.5. 289-292. June 1971.

Lewis, Phillips L. & Naidig, Peter. The University Health Service & the Community Health Center: An Example of a Successful Relationship. Jrnl of Amer. Coll. Health Assoc.. 24.4. 235-8. April '76

Michaels, Robert & Reifler, Clifford B. Mental Health Ser vices for Students - Cost, Benefit & Value. Jrnl of Amer. Coll. Health Assoc. 24.4. 208-10 Apr. '76

National Institute of Mental Health. Facts About College Mental Health. ERIC/RIE Nat'l Inst. of Ed. Oct. 1973. (ED 077371)

Miller, Theresa M. But is it Psychotherapy? Community College Frontiers. 4.2. 4-9. Winter 1976.

Nicoletti, John A.Jr. The Use of Anxiety Management Training in the Treatment of Generalized & Specific Anxieties. ERIC/RIE. Nat'l Inst. of Ed. Sept 73. (ED 075737)

Nidorf, Lewis J. Community Mental Health Model Applied to Student Personnel Work. Jrnl of Amer. Coll. Health Assoc. 11.1. 19-27. Jan. 1970

Weiss,

Nigl, Alfred J. &/Stephan D. Effects of Presenting Symptom & Therapist Orientation on Treatment Outcomes: A Follow-up Study of Breif Therapy With College Students. Jrnl of Amer. Coll. Health Assoc. 24.4. 203-7. Apr. '76

.... A Consumer Analysis of Campus Mental Health. Jrnl of Amer. Coll. Health Assoc. 25.5. 293-300. June '77.

Reifler, Clifford B. Epidemiologic Aspects of College Mental Health. Jrnl of Amer. Coll. Health Assoc. 19.3. 289-292. June 1971

Reinhold, John. E. User & Nonusers of College Counseling & Psychiatric Services. Jrnl of Amer. Coll. H ealth Assoc. 21.3. 201-08. Feb.'73

Rockwell, W.J. & & others. Individual Versus Group Brief Treatment Outcomes in a University Mental Health Service. Jrnl of Amer. Coll. Health Assoc. 24.4. 186-90. April '76

Schwartz, Leslie J. & others. Group Experience for Nonpatient Undergraduates With Difficulties in Making Decisions. Jrnl of Amer. Coll. Health Assoc. 24.4. 195-7. April '76.

Shaevitz, Morton H. How Are We to Respond As the Budgets Get Tighter & The Voices Louder? Jrnl of Amer. Coll. Health Assoc. 26.3. 124-6. Dec. '77.

Sinnett, E.R. The Rehabilitation Living Unit - A New Resource for the Emotionally Disturbed Student. Jrnl of Amer. Coll. Health Assoc. 17.4. 332-39. Apr. '69

Sue, Stanley. Training of Third World Students to Function as Counselors. Jrnl of Counseling Psychology. 20.1. 73-78. Jan. '73.

..... & Sue, Gerald. MMPI Comparisons Between Asian-Americans and Non-Asian Students Utilizing a Student Health Psychiatric Clinic. Jrnl of Counseling Psychology. 21.5. 423-427. Sept. '74.

Szasz, Thomas S. The Ethics & Politics of College Psychiatry. ERIC/RIE. National Institute of Education. 1967. (ED 013465)

Texas Tech University. University Provisions for Psychiatric Services. ERIC/RIE Nat'l Inst. of Ed. Dec. 1970. (ED 04 1312)

Thelan, Mark H. & Varble, Dwane L. Comparison of College Students Seeking Psychotherapy with Nontherapy Students on Coping & Defense Scales. Jrnl of Clincial Psychology. 26.1. 123-4. Jan. 1970

WICHE, Quality of Educational Life, Priorities for Today. ERIC/RIE. Nat'l Inst. of Ed. Apr. 1974. (ED 084948)

WICHE, Research Profiles: Student & Campus Characteristics. ERIC/RIE. Natl Inst. of Ed. Aprl. 74. (ED 084954)

Western Interstate Commission for Higher Education. (WICHE) New Designs: Prevent Educational Casualties - Promote Educational Growth. ERIC/RIE. Natl Inst. of Ed. Sept. 1974. (ED 084947)

WICHE. A Process for Continuous Institutional Renewal. ERIC/RIE. Natl Inst. of Ed. Sept. '74. (ED 084955).

Winer, Jerry A. & others. Non-White Student Usage of University Mental Health Services. Jrnl of Coll. Student Personnel. 15.5. 401-412 Sept. '74.

Wogan, Michael & others. Influencing Interaction & Outcomes in Group Psychotherapy. ERIC/RIE. Natl Inst. of Ed. Sept. '75. (ED 105302)